The Care of Diabetes

Diabetes care has changed dramatically over the past two decades. There have been several major developments, in particular the understanding that the patient must have prime responsibility for the disease and that the role of the health professionals is to support and educate the patient. Secondly, new forms of treatment, both insulin and oral, have become available; and thirdly the introduction of new ways of monitoring control, particularly the use of HbA_{1C}, has greatly improved modern care.

The introduction of blood glucose self-monitoring, together with diabetes nurse education, led the revolution. From a doctor-dominated situation, we moved to the patient as the focal point of care. The concept of diabetes teams evolved, with the patient and their family an integral part of the team. Initially, by far the majority of formal diabetes care took place in hospitals, but it was evident that there were too many patients for hospital-based care to be the sole provider.

The first reports of a policy of discharging patients with diabetes from hospital but without providing any educational support and without involving general practitioner educationalists were unfortunate. Hayes and Harries showed that patients suffered appreciably poorer care in general practice and indeed showed higher mortality.[1] This unacceptable finding stimulated a vigorous response in primary care and Singh *et al.* showed that high quality care was perfectly possible in general practice.[2] A number of primary care enthusiasts, particularly in the various primary care groups, have continued to refine the potential in primary care.

In most cases the care of Type 2 diabetes has been concentrated in primary care, with insulin-treated patients tending still to attend the hospital clinics. Type 2 diabetic patients often have co-existing pathology on diagnosis and will unfortunately usually develop it over time. The need for systematic clinical vigilance is therefore essential.

Specialist and Generalist Contributions

The contribution of specialists in general, and in diabetes in particular, is the concentration of experience and the opportunity to study in depth large numbers of patients who have a single condition or disease. Most research on diabetes has been done by specialists. Specialist medicine has been responsible for most of the advances in diabetic care in this century.

The advantages of generalist care are essentially the person-to-person relationship which exists and the fact that all chronic diseases and especially diabetes have important implications for the way patients live: at home, in their work and in their families. The family physician is the best placed of all the health professionals to know and understand the patient as a whole person and to assist in their physical, psychological and social support.

Most families register with family physicians and the average duration of care is 12 years, with an average contact rate between patients and general practitioners of 5 episodes per year,[3] so continuity of care is still a reality. Primary care teams are therefore well placed to encourage patients to develop a long-term plan for the management of their own disease. Studies in the USA show that involvement by patients improves outcome.[4]

The Measurement of Quality

The latest research[5,6] shows that, in Type 1 diabetes, complication rates rise sharply once the average level of HbA_{1C} rises above 7.5 %. This figure is emerging as one of a small number of markers of quality control. It is assumed but not proven that similar levels will apply in Type 2 diabetes.

This is a tough test. Home[7] has helpfully reported the figures from the Newcastle specialist diabetic service which are:

Non-insulin-dependent diabetic patients	HbA_{1C} under 7.5 %	65 %
Insulin-dependent diabetic patients	HbA_{1C} under 7.5 %	39 %

The central single failure in primary care in the management of chronic diseases in the past has been lack of system and follow-up. Now that these can be put right with computerized diagnostic registers and computerized appointment follow-ups, it is perfectly possible for high quality care to be provided. Mean glycosylated haemoglobin levels are still unsatisfactorily high in general practice with a mean of 10.5 %[8] but some practices are now reporting that even with about 150 patients in a single practice the mean glycosylated HbA_{1C} can be maintained below 7.5 % (Evans PH *et al.*, 1998, personal communication).

Since Type 2 diabetes is the commonest form of diabetes, the majority of diabetic patients are now getting most of their care in the primary sector. The sharp increase in prevalence (as high as 3.5 % of whole registered populations in some general practices) means that inevitably the main site will now be in primary care rather than in hospital. This calls for a major new partnership between primary and secondary care, with the development and implementation of educational initiatives and the systematic monitoring of the best quality markers that exist for all patients with all forms of diabetes.

The enormous progress made in recent years in the development of primary-care-based diabetes services is thus to be welcomed. However, there are still many caveats. Effective training and support for primary and secondary care teams is essential. Currently only a small

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minority of GPs and practices show enthusiasm for providing comprehensive diabetes care for all their patients. The 'leading edge' practices are an example to us all, but there is wide variation in the level of commitment and in the standards achieved. A joint initiative between RCGP, RCP, BDA and RCN to consider a system for accreditation of diabetes services is being started. Above all, excellent communication between all those involved in diabetes care is essential, as is strong patient involvement. Management needs to be reminded that good care of diabetes by primary care teams complements rather than replaces the specialist services of secondary care and that an improvement in overall standards will require additional funding. In the meantime, it is up to all of us in both primary and secondary care to help raise standards of care for our patients and put pressure on the government to increase available resources.

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